South West **LHIN**

South West Local Health Integration Network
Annual Report 2010-11

Ontario
Local Health Integration Network

Table of Contents

Message from Jeff Low, Board Chair 4

Board members as of March 31, 2011 4

Message from Michael Barrett, Chief Executive Officer 5

Large geography and almost a million people 6

Population profile 7

Progress report on Integrated Health Service Plan 2010-13 priorities 10

I - Enhance capacity and integration of primary, specialized, and community-based care, with a focus on the following populations: 10

i. Seniors and adults with complex needs *10*

ii. People living with mental health and addiction challenges *11*

iii. People living with or at risk of chronic disease *12*

II - Enhance access and sustainability of hospital-based treatment and care focusing on: 13

i. Emergency Services *13*

ii. Medicine, Surgical and Critical Care Services *13*

Aging at Home Update 15

eHealth Initiatives in the South West LHIN 17

Community Engagement Activities 18

Engagement with Aboriginal and Francophone Communities 20

Integration Activities 22

Ministry/LHIN Accountability Agreement Performance Indicators 24

Operational performance 26

Financial Statements 27

Message from Jeff Low, Board Chair

In February 2011 I was appointed Chair of the Board of Directors for the South West LHIN. My commitment to the health care system dates back over 16 years. The role of the South West LHIN is vitally important to ensuring a quality health care system is sustainable for future generations.

The South West LHIN has seen many successes in its short five years, yet much work remains to be done. The Board's role, in addition to providing oversight, is to ensure that we consistently and steadily move toward the vision of a quality health care system that is fully integrated. This can only be done with the help and work of our health service providers.

Together with local health care providers, we are building a system where programs and services work together, where individuals and their families are able to access and receive the care they need, when they need it. We are putting people at the centre of the system, closing gaps between services and removing duplication.

Our access to care strategy has a strong focus on quality improvement – making it a perfect fit with the government's new legislation, the *Excellent Care for All Act* (2010) and with the South West LHIN's Blueprint Vision 2022.

I look forward to working with the other Board members, with our provider Boards and with the LHIN team. Our Board meetings are always open to the public, and full agendas are posted well in advance. We welcome any member of the public who wants to see local health care decisions being made locally for the benefit of the residents of the South West LHIN. All Board members, including myself, live within the LHIN boundaries; we are your neighbours.

Board members as of March 31, 2011

(Please note there is one vacancy as of March 31, 2011)

Jeff Low (London)
Chair
February 7, 2011 - February 7, 2014

Linda Stevenson (St. Thomas)
Vice Chair
May 16, 2007 – May 15, 2012

Kerry Blagrave (Listowel)
Secretary
June 1, 2005 – June 1, 2011

Ron Bolton (St. Marys)
May 12, 2010 – May 11, 2013

Murray Bryant (London)
May 17 2006 – May 16, 2011

Sheryl Feagan (Goderich)
June 17, 2010 – June 17, 2013

Ron Lipsett (Annan)
July 28, 2010 – July 28, 2013

Janet McEwen (London)
June 1, 2005 – June 10, 2011

Members whose terms expired during 2010-11

Ferne Woolcott, June 16, 2010 Barrie Evans, June 17, 2010 John Van Bastelaar, January 4, 2011

The South West LHIN gratefully acknowledges the contributions made by Ferne, Barrie and John during their years of service on the Board. All were among the first appointees to the Board, and their guidance and dedication were most valuable in setting the LHIN on its current course.

Message from Michael Barrett, Chief Executive Officer

The past year has been an exciting one for the South West LHIN. We started the year with the official launch of Health System Design Blueprint – Vision 2022 that outlines the future state vision of a fully unified health system of care. The Blueprint represents a strong first step toward realizing a better health care system that is essential to meet the future needs of our population. A long term vision, however, can only be realized if supported by concrete action plans. The Integrated Health Service Plan 2010-13 (IHSP), also launched on April 1, 2010, identifies the strategic directions and active steps we need to take to move toward an integrated health system of care.

The year 2010-11 saw our health service providers implement programs and initiatives that have had direct positive impact on the day to day lives of tens of thousands of residents in the South West LHIN. Many provide excellent examples of several organizations working together to achieve one goal – better care for all. Some of these successful initiatives include:

- More than 6,500 people living with diabetes have received enhanced care thanks to the *Partnerships for Health* initiative that brought together multi disciplinary teams that included the patient as a key team member in managing their diabetes. This initiative's success will be spread to other practices and will be applied to the management of other chronic diseases.
- Acute care patients are receiving hospital care in the right location either in a community hospital closer to home or a more specialized centre if that's the level of care needed. Under the *One Number* patient access and flow project, specialized acute care beds are freed up for the sickest patients.
- SPIRE – South West Physician Office Interface to regional medical records - provides a secure electronic interface between hospitals' Electronic Patient Records (EPR) and participating regional physicians' offices.
- Life and Limb, no refusal policy ensures that the most critically ill patients will not be referred to another hospital because of lack of bed space. This protocol emphasizes a 'patient first, bed second' philosophy.

These are but a few examples of the successes achieved through the dedication and hard work of our health service providers. Many more can be found on our website.

The past year also saw the South West LHIN step into the social media world. No longer the purview of young students, our followers are from all walks of life and every age group. Through Facebook, Twitter, and YouTube, we have been able to engage with thousands of people who may have previously felt disconnected from the health care system. Through social media, not only can they learn about the system, but they can comment on it, and provide input to help guide the future. Our YouTube channel contains real stories about real people. We are committed to integrity and transparency in all we do, and through social media we have the ability to interact directly with the people we serve.

In closing, I want to thank all our health service providers who, tirelessly, day after day, work on the front lines helping patients, clients and residents achieve a better quality of life. I also want to thank the LHIN staff for their hard work, and the Board of Directors for their direction and support.

Large geography and almost a million people...

...that's the South West LHIN

The South West LHIN stretches from Long Point in the south to Tobermory in the north, and serves 7.5 percent of the province's residents. Not only is our geography vast, but the diversity of our communities includes agricultural, where neighbours can be several kilometers apart, small towns and larger cities where a few steps across the hall will bring you to your neighbour's front door. Our population includes five First Nations reserves, francophone communities, and a large proportion of seniors.

The LHIN funds over 150 health service providers, among which are community service agencies that provide in-home or community supports that allow people to remain in their homes, be discharged from hospital sooner, and avoid admission to long-term care homes. The services these agencies provide run the gamut for light housekeeping services to adult day programs for people who may not have access to a caregiver during the day.

The 76 long-term care homes funded by the South West LHIN provide a welcoming and safe environment when home care services are no longer sufficient. Over 7,000 people are cared for by the professional staff in our long-term care homes.

The LHIN also funds the South West Community Care Access Centre whose case managers help the residents of the LHIN navigate the health care system and obtain appropriate supports by assessing needs, working collaboratively with hospitals in discharge planning, ensuring that individuals' care needs are met in the most appropriate setting. The CCAC also coordinates placement in long-term care homes when care requirements are beyond what could be accommodated in the individual's home.

The South West LHIN funds 20 hospital corporations (32 sites) that vary greatly in size and in the types of services offered. Each has an important role to play in the lives of the residents of the South West.

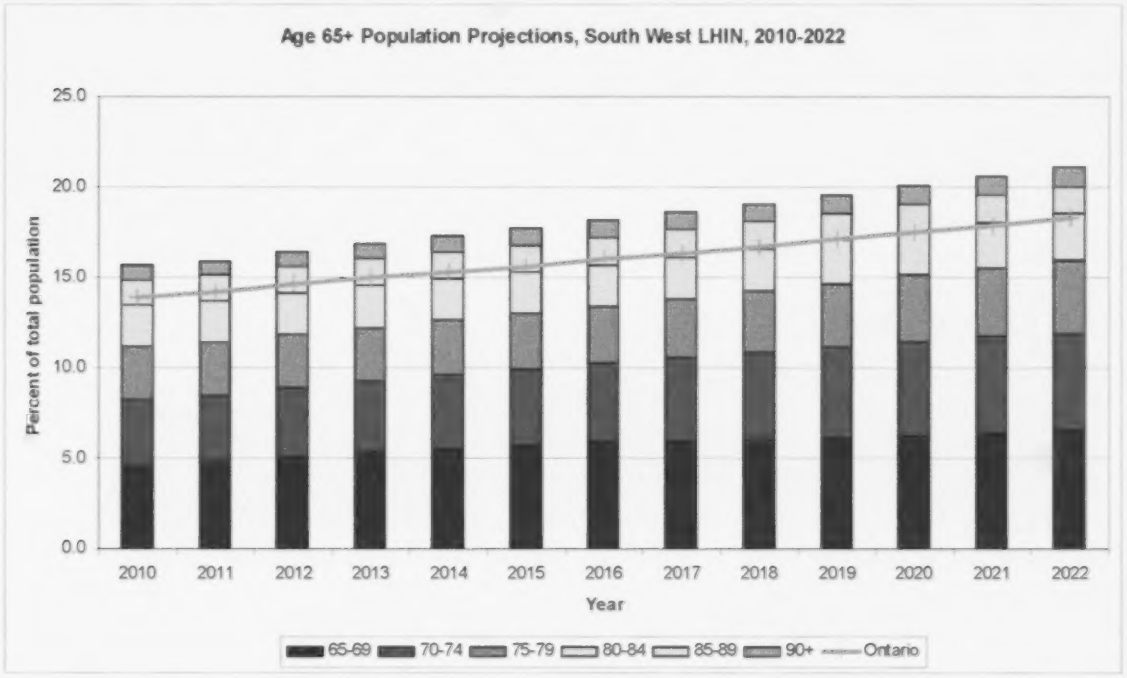
The smaller community hospitals serve their immediate neighbours when care of a less specialized nature is needed. This allows patients to remain closer to their family and friends as they recuperate. The larger regional hospitals serve a wider area and offer more specialized care, including some cancer surgeries and more sophisticated diagnostic testing such as MRIs or CT scans.

London is home to two large teaching hospitals, St. Joseph's Health Care London, and London Health Sciences Centre. These two organizations have been recognized internationally and include some of the best specialists in the world. The London hospitals provide the highest level of specialized care for residents of the South West LHIN as well as individuals from neighbouring LHINs. Through advances in telemedicine, the London-based specialists are also available to more remote hospitals and can often avoid having to transfer a medically fragile patient by providing advice and guidance via video conferencing.

Population profile

As we plan for a health system that meets the needs of all the people of the South West LHIN, we must recognize the diversity of needs of our Aboriginal and Francophone communities, the rural populations, and the large urban centres. Statistics about the people of the South West LHIN include the following:

- Of the approximately 900,000 people in the region, most (85%) list English as their mother tongue. However, French is the mother tongue for close to 11,000 people (1.2%). An additional 7,300 (0.8%) do not speak either official language.
- 1.4% of people in the South West identify themselves as Aboriginal. This compares with 2% for the province as a whole and represents a significant population with unique health challenges. There are five reserves in the South West with a population of close to 4,500 people. It is estimated that an additional 7,200 Aboriginals live off reserve.*
- The population in the South West LHIN is projected to grow to just over 1 million people by 2017.
- The percentage of the population aged 65+ in the South West LHIN is currently 15.6%. This compares with 13.9% for the province as a whole. As shown in the following table, the senior population is expected to grow rapidly in the coming years, to 21.1% (18.3% in Ontario) by the year 2022. **

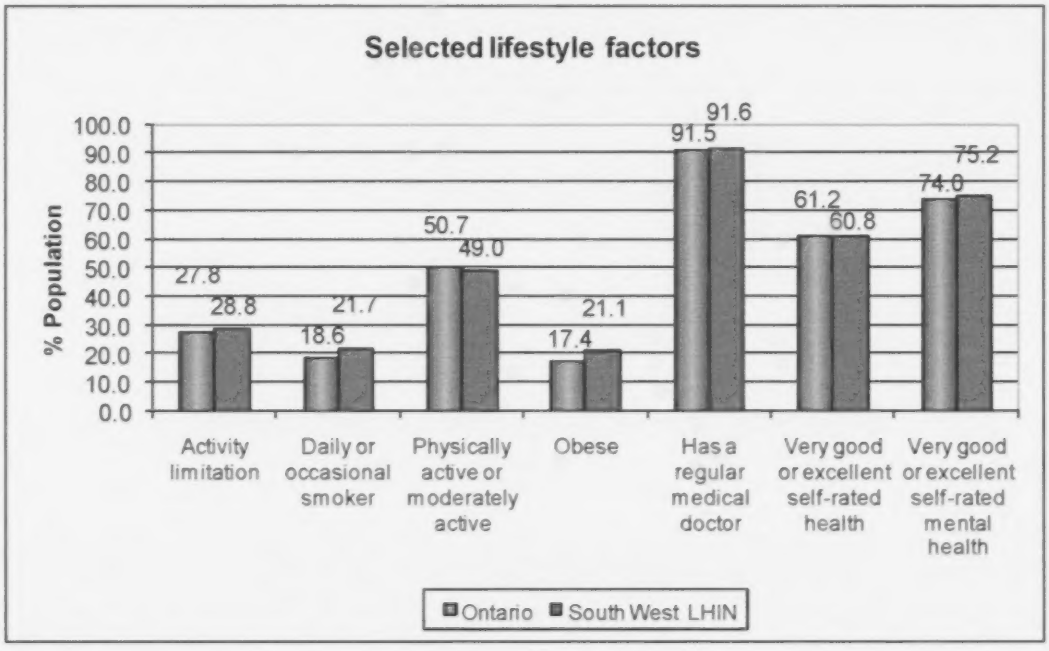


Population health profile***

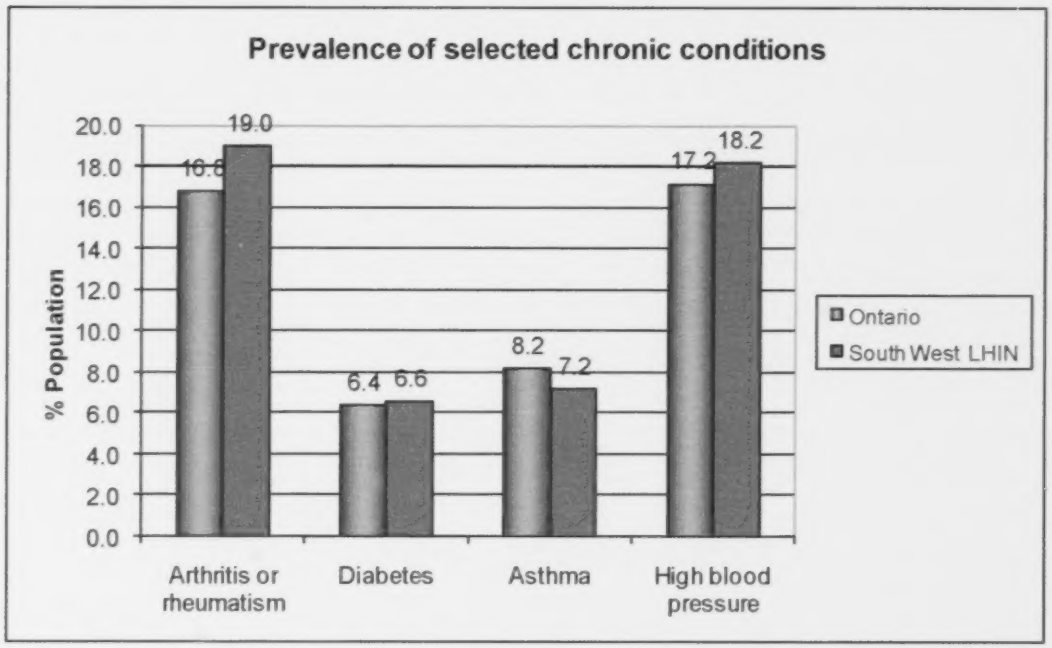
When developing a health care system for the future, it's important to understand today's needs, and the lifestyle factors of today's population which are likely to influence the health care needs of tomorrow. Following are some of the factors, and their prevalence within the South West LHIN, that must be considered as we move forward with the transformation of the health care system.

- Just over 60% of people in the South West rated their health as very good or excellent in 2009.
- The incidence of diabetes in the South West LHIN was 6.3% in 2009. This compares with 6.4% for the province.
- 16% of people over age 12 report alcohol consumption of five or more drinks at one time, at least once a month, compared to 15.6% for the province as a whole.
- 22% of the residents of the South West LHIN report high stress levels in their lives, compared with 24.3% of Ontarians.
- Canadian Community Health Survey data for 2009 suggests that 21.1% of adults aged 18+ in the South West are obese.
- 91.6% of South West LHIN residents reported that they had a regular family physician in 2009. This compares with 91.5% for Ontario.

The table below graphs some of the lifestyle factors and compares these to provincial statistics.



The following table shows the prevalence rates of various chronic conditions among the residents of the South West LHIN compared to the Ontario population.



Data Sources: *Indian and Northern Affairs Canada First Nation Profiles and Registered Indian Population by Sex and Residence, 2006. **Ministry of Finance Population Projections, Population Projections by Gender, Age and LHIN of Residence, 2006-2016, Health System Intelligence Project. ***Statistics Canada, Canadian Community Health Survey, 2009.

Progress report on Integrated Health Service Plan 2010-13 priorities

The Integrated Health Service Plan (IHSP) 2010-13 continues the implementation efforts of our first IHSP. It prioritizes the steps needed to achieve our Blueprint goal of an integrated health system of care by 2022. The IHSP identifies two strategic directions:

I - Enhance capacity and integration of primary, specialized, and community-based care, with a focus on the following populations:

i. Seniors and adults with complex needs

Develop and implement an integrated model of care for high-risk seniors - Through Aging at Home funding, the South West LHIN initiated a pilot project to understand ways health care providers across sectors could better identify and support seniors living at home who are at increased risk of avoidable emergency department visits or hospitalization. The knowledge gained from the London-based pilot was significant; a total of 46 people aged 75+ were identified during a hospital stay to be at risk upon discharge home and took part in the high-risk seniors project.

In addition to intensive case management services through the South West Community Care Access Centre, clients also received home visits from a nurse practitioner who responded to their medical needs, reconciled their medications and ensured they were used properly, particularly upon return home from hospital. Clients also received as many as four visits a day from a personal attendant and access to a 24-hour pager in case of urgent need (to be used in situations such as incontinence, falls, etc.) as part of enhanced supports for daily living. The program is not only helping to support elderly people in their homes, but also helps reduce the risk of them being admitted to hospital or requiring premature admission to long-term care homes.

Going forward, the successes and lessons learned from the pilot in London will be incorporated into the South West LHIN's Access to Care Strategy.

Develop and implement a coordinated system of care for seniors with behavioural issues Across the province, the number of residents living in long-term care homes with potentially volatile and aggressive behaviours is increasing. This can be attributed to a number of factors including an aging population with increased incidence of Alzheimer's disease, other related dementia and mental illness. To assist with enhancing quality of life for these residents and people living in their own homes, five seniors mental health response teams will be working across the LHIN within geographic geriatric cooperatives to better respond to their needs – whether in long-term care homes or in the community.

This initiative focuses on people over the age of 65 years who have significant emotional, behavioural or cognitive problems which interfere with their ability to function independently or which seriously affect their feelings of well-being and relationships with others. This initiative involves the development of a model of care, the establishment of protocols between tertiary, Schedule 1, Long-Term Care Homes and community agencies, the creation of an evaluation framework, and installation and use of telemedicine equipment to enhance clinical interventions.

Enhance services and supports for Aboriginal seniors – When compared to the general population, we know there are significant health gaps and poorer health outcomes for Aboriginal seniors. Aboriginal seniors have higher rates of chronic conditions and disabilities than other Canadians of the same age and

their access to primary health care services is also limited. Many Aboriginal people aged 45 or older have experienced cultural bias and discrimination in interactions with the western modeled health care services and wish to return to traditional ways with self-governance and administration of health care programming. The South West LHIN recognizes the need for culturally appropriate and safe health care services for Aboriginal seniors to support management of chronic conditions, to prevent delays in seeking care, prevent complications and reduce use of high-cost health care services.

With leadership from the South West LHIN Aboriginal Committee, a culturally-safe and community-responsive strategy is being created for implementation, co-ordination, integration and on-going development of community-based health care resources and services to serve Aboriginal seniors with complex health issues at risk for hospitalization and/or long-term care placement. Funded through the South West LHIN Aging at Home Initiative, there are three key goals of the project:

1) To increase opportunities for integration of culturally safe practices across health care services serving Aboriginal residents of the South West LHIN;

2) To ensure effective culturally appropriate service delivery to Aboriginal seniors; and,

3) To expand the services and supports for Aboriginal seniors to assist them to live at home.

Enhance capacity and coordination of transportation services - Two Aging at Home projects are showing positive results in the North and Central areas of the LHIN. The Grey Bruce project involves Home and Community Support Services as they work together to improve coordination of resources across their vast geography.

Similarly, in the Huron-Perth area, seniors or others who are challenged to get to medical appointments or other services no longer need to worry about how they will get there, thanks to the "Easy Ride" program, a partnership of seven area community agencies. Central dispatch services for all of the agencies involved are now coordinated. Each of the partners retains ownership and operation of their vehicles, but the central office has access to them and is able to use web-based scheduling software to book trips based on what makes the most sense. LHIN will continue to work with HSP partners across the LHIN to identify how to leverage capacity within available resources.

Define role of and access to complex continuing care beds and rehabilitation services – This priority is an element of the Access to Care initiative that is being adopted across the 14 LHINs. Access to Care involves three major components:

- Implementation of Home First , a philosophy of integrated care that focuses on early identification of high needs seniors in hospital and the exploration of all support options at home before referral to a long-term care home;
- Realignment of community capacity of Assisted Living/ Supportive Housing/ Adult Day Programs and implementation of the expanded role for Community Care Access Centres to access these services; and
- Realignment of the capacity of Complex Continuing Care and Rehabilitation beds in hospitals.

ii. People living with mental health and addiction challenges

Mental health divestment: In 1997, the Health Service Restructuring Commission (HSRC) provided directives for a number of system-level changes in the region. Among those directives was divestment of mental health services which was to happen in three tiers – the first was the divestment of provincially-operated mental health services in London and St. Thomas to St. Joseph's Health Care London, which was completed in 2001.

Several partners have been working on the second tier of activity: divestment of inpatient services at the Regional Mental Health Care (RMHC) sites in London and St. Thomas so that clients are able to receive care closer to home. In late 2010, 50 beds, services, clients and associated resources were transferred to Grand

River Hospital in the Kitchener-Waterloo area. Another 59 will go to Windsor in 2011/12, 14 to Hamilton in 2013/14 and 15 (Schedule 1 beds) to St. Thomas Elgin General Hospital.

Over the next few years, an additional 70 RMHC beds will be closed prior to moving to the new mental health facilities inLondon (156 total beds) and St. Thomas (89 forensics beds.) What has been referred to in the past as Tier 3, speaks to enhancing and creating community capacity, work that is being carried out in 2011/12.

Community Services:
Significant planning work also took place for the new Addiction Supportive Housing (ASH) Program operated by Addictions Services Thames Valley (ADSTV) in partnership with MH&A providers throughout the region, enabling the first eight of 32 supportive housing units to open in early March. This program provides homeless people who need addictions supports personal housing and support through addiction assessment, treatment planning, life skills, and self management. With the leadership of the ADSTV, the partners have created an integrated service delivery model that will better serve a population that we know spends a lot of time in emergency departments, waiting rooms, shelters and the addictions system. The goal is to better serve these individuals so they are supported and can best learn how to manage themselves and leave the program to eventually get their own permanent housing.

Through an integration of services, specially-trained volunteers with the London and District Distress Centre (LDDC) is now answering all crisis calls for the CMHA-London Mental Health Crisis Services (LMHCS) and then triaging the calls that require face to face intervention to the LMHCS. This allows the LMHCS staff resources who previously responded to the telephone crisis calls to be redeployed to other face-to-face services, while those calling the crisis lines continue to receive quality service.

iii. People living with or at risk of chronic disease

The South West LHIN is undertaking implementation of Chronic Disease Prevention and Management strategies with an initial focus on the Ontario Diabetes Strategy. A South West Regional Coordination Centre (RCC) was created with a goal to improve the health and health outcomes for people living with and at high risk of developing diabetes. The centre is focused on looking for care gaps and facilitating improvement in the overall management of diabetes.

The RCC will build on the work completed through the formal three-year *Partnerships for Health* project. The project facilitated the creation of integrated care teams focused on improving the quality of care for their diabetes patients. A key enabler for the success of this project was the focus on supporting use of available eHealth technologies such as electronic medical records (EMRs). While the formal project ended May 31, 2011, the project is continuing under the new South West LHIN Quality and Process Improvement program.

With Aging at Home funding, the South West LHIN initiated a program focused on enabling health service providers within the region to expand their skill set to empower their patients with one or more chronic disease(s) to self manage their condition. Coaches across the LHIN have been trained and many people are participating in workshops that provide them with skills and knowledge to better care for themselves.

Work continues in improving access to chronic kidney disease (kidney dialysis) services through satellite locations of the London Regional Renal Program, as well as through the use of peritoneal dialysis at some long-term care homes in the South West.

II - Enhance access and sustainability of hospital-based treatment and care focusing on:

i. Emergency Services

The provincial *Pay-for-Results* program provides hospitals across Ontario with incentive to drive down emergency room (ER) wait times and ensure patients can get the emergency care they need, sooner.
Hospitals in the South West LHIN received $3.65 million from the program. Hospitals receiving the funding commit to treat more patients within set waiting time targets, aiming to improve performance by 15 per cent over the course of the year.

To reach the target, hospitals will use the funds to do things like:

- expand staffing as part of emergency department teams and reorganize how these teams interact to encourage more collaboration;
- create designated areas in the ER for rapid assessments to improve patient flow;
- implement process improvement and Lean methodologies (such as the Emergency Department
  Process Improvement Program) for long term sustainable improvements in patient flow through
  the hospital.

London Health Sciences Centre (Victoria and University sites), St Thomas Elgin General Hospital (STEGH) and Grey Bruce Health Services were included in the 2010-11 fiscal year of the *Pay for Results* program. STEGH participated in the provincial ED Emergency Department *Process Improvement Program* (PIP). Additional South West LHIN sites that participated in modified PIP program including: Alexandra Hospital (Ingersoll), Alexandra Marine and General Hospital (Goderich), Middlesex Hospital Alliance, South Bruce Grey Health Centre & Woodstock General Hospital.

ii. Medicine, Surgical and Critical Care Services

Hip and knee project – The South West LHIN approved funding to implement key components of the hip and knee project (funded in 2009/10) to develop:

- evidence based guideline for Family Physicians when referring patient to an orthopaedic surgeon
- a common referral form and process to be used across the LHIN
- education tools for individuals requiring a joint replacement

In addition, a website, hosted on thehealthline.ca was launched and offers common information along a patient's journey of care as well as the hospitals' education booklets. This initiative also oversaw the development and implementation of common order sets as the foundation to a care pathway.

Hip Fracture Project – Hip fracture wait times – the amount of time it takes for a patient to make it into surgery from the time they are admitted into an emergency department with a broken hip - have been in the sights of local health care leaders. A lot of work still needs to be done as we know that people who have their hip repaired within 48 hours have better outcomes.
Working under the direction of the Ontario Orthopaedic Expert Panel, the Bone and Joint Health Network (BJHN) released care maps and other research-based recommendations to assist Ontario hospitals to meet the target of 90 per cent of patients receiving surgery within 48 hours of their hip fracture.
Improvements are underway across the South West LHIN as the BJHN care plans are implemented at hospitals that perform hip fracture repairs. They include: London Health Sciences Centre, St. Thomas Elgin General Hospital, Strathroy Middlesex General Hospital, Stratford General Hospital, and Grey Bruce Health Services - Owen Sound site and Woodstock General Hospital.

Cancer Surgery Wait Times Improvement - The South West LHIN continues to report long waits for cancer surgery. London Health Sciences Centre (LHSC) and St. Joseph's Health Care (SJHC) provide approximately 76% of South West LHIN's cancer surgeries and continue to fulfill and typically exceed contracted volumes of surgeries.

In 2010, the South West LHIN provided funds to LHSC to review wait time data and to create reports targeting queuing improvements. This work resulted in a strong focus in urology, and identification of a clinician to lead a regional process to improve access to urology.

The South West LHIN funded an initiative to build on this foundation and to align urology service deliver to maximize capacity and to develop and implement new models for queuing patients for urology cancer surgery procedures without negatively impacting other urology surgical procedures. Lessons will be taken from this focused area to improve access to cancer surgery for other disease sites where applicable.

Critical Care - A significant amount of progress has been made in programs designed to improve access to critical care services in the South West LHIN since creation of the Critical Care Network of providers in 2009.

One of the first accomplishments of the group was to create a detailed inventory of all critical care beds in the local system, identifying the types of supports each can provide, who the physician specialists are who provide support and more. This work has enabled creation of plans for minor and moderate surges in capacity – which means identifying the human resources, equipment needs and space to surge to 115 per cent of current capacity for a "minor" surge and up to 150 per cent capacity for a "moderate" surge. The ability to be able to surge in capacity is important to assist with providing care in a variety of situations such as response to a mass casualty situation or pandemic.

Life or Limb No Refusal Policy - We have all heard the stories about patients who are critically ill or injured being flown across the province, country or even into the United States to receive access to timely care due to inaccessibility, locally. On February 1, 2011, hospitals across the South West LHIN joined together to implement a new Life or Limb - No Refusal policy. This new philosophy for care is expected to dramatically reduce the practice of sending critically-injured patients out of region by ensuring better collaboration among hospitals. Together, physicians, nurses, hospital administrators and critical care representatives have worked with the LHIN's Critical Care Lead to develop appropriate care paths and processes for the Life or Limb policy.

Care for patients requiring long-term mechanical ventilation – Thanks to the dedicated staff at London Health Sciences Centre (LHSC), a long-term mechanical ventilation project funded by the South West LHIN and an incredible amount of support from community agencies and family, some people who require long-term assisted breathing no longer have to live in an intensive care setting. More than 180 clients from across southwestern Ontario living at home or them people to live in the community or at home, greatly improving their quality of life, but also frees up critical care beds.

The long-term mechanical ventilation project was designed to provide access to quality, safe and appropriate care for individuals requiring long-term ventilation. This is done through the dedication of health care professionals – from hospital to community – working closely together and by building partnerships and breaking down silos between care providers. Long-term ventilation clients need significant support on an outpatient basis and partners in the community who are appropriately resourced.

The project team is creating a regional interdisciplinary system for these patients. They are putting together standards to clarify roles and responsibilities, ensure clear communication and create strong educational strategies for care providers and patients. Another part of the project involved a quality improvement initiative where the processes involved in getting a long-term ventilation patient out of critical care into a more appropriate setting (such as complex continuing care at Parkwood) were streamlined.

Aging at Home Update

The Aging at Home (AAH) strategy was designed to work towards matching the needs of seniors and their caregivers with the appropriate local support services and avoiding the unnecessary loss of independence due to premature admission to long-term care homes or hospitals. The AAH strategy is of critical importance, both for its potential to improve the lives of Ontario seniors by keeping them living independently and healthy in their homes, and also because it will help ensure the sustainability of the overall health system.

The South West LHIN received the following AAH funds over 3 years:

- 2008/09 (Year 1) – $7M
- 2009/10 (Year 2) – $17.4M (increase of $10.4M)
- 2010/11 (Year 3) – $27.5M (increase of $10.1M)

In Years 1 and 2 of the *South West LHIN AAH Strategy,* 27 projects were approved to move forward. In 2010/11 quarterly performance reports were monitored by LHIN staff to ensure projects were achieving their performance indicators and milestones in addition to reporting of their financial components.

In its third year, the aim of the AAH program evolved from its original inception. The Ministry of Health and Long-Term Care moved the focus of the program from one which was intended to keep seniors living independently in their own homes to a program which aims to reduce the number of Alternate Level of Care (ALC) patients in hospitals. The evolution of the program is intended to assist in addressing the significant pressures facing hospitals with patient flow, capacity and emergency department wait times.

The five projects funded in year three include:

1. The South West LHIN initiated a pilot project to understand ways health care providers across sectors could better identify and support seniors living at home who are at increased risk of avoidable emergency department visits or hospitalization. The knowledge gained from the London-based pilot was significant; a total of 46 people aged 75+ were identified during a hospital stay to be at risk upon discharge home and took part in the high-risk seniors project.

   In addition to intensive case management services through the South West Community Care Access Centre, clients also received home visits from a nurse practitioner who responded to their medical needs, reconciled their medications and ensured they were used properly, particularly upon return home from hospital. Clients also received as many as four visits a day from a personal attendant and access to a 24-hour pager in case of urgent need (to be used in situations such as incontinence, falls, etc.) as part of enhanced supports for daily living. The program is not only helping to support elderly people in their homes, but also helps reduce the risk of them being admitted to hospital or requiring premature admission to long-term care homes. Going forward, the successes and lessons learned from the pilot in London will be incorporated into the South West LHIN's Access to Care Strategy.

2. Enhancement of Services and supports for Aboriginal Seniors - When compared to the general population, we know there are significant health gaps and poorer health outcomes for Aboriginal seniors. Aboriginal seniors have higher rates of chronic conditions and disabilities than other Canadians of the same age and their access to primary health care services is also limited. Many Aboriginal people aged 45 or older have experienced cultural bias and discrimination in interactions with the western modeled health care services and wish to return to traditional ways with self-governance and administration of health care programming. The South West LHIN recognizes the need for culturally appropriate and safe health care services for Aboriginal seniors to support management of chronic

conditions, to prevent delays in seeking care, prevent complications and reduce use of high-cost health care services.

With leadership from the South West LHIN Aboriginal Committee, a culturally-safe and community-responsive strategy is being created for implementation, co-ordination, integration and on-going development of community-based health care resources and services to serve Aboriginal seniors with complex health issues at risk for hospitalization and/or long-term care placement. Funded through the South West LHIN Aging at Home Initiative, there are three key goals of the project:

a) To increase opportunities for integration of culturally safe practices across health care services serving Aboriginal residents of the South West LHIN;
b) To ensure effective culturally appropriate service delivery to Aboriginal seniors; and,
c) To expand the services and supports for Aboriginal seniors to assist them to live at home.

3. Behavioural Support System for Older Persons with Behavioural Challenges (BSS Project) - Across the province, the number of residents living in long-term care homes with potentially volatile and aggressive behaviours is increasing. This can be attributed to a number of factors including an aging population with increased incidence of Alzheimer's disease, other related dementia and mental illness. To assist with enhancing quality of life for these residents and people living in their own homes, five seniors mental health response teams will be working across the LHIN within geographic geriatric cooperatives to better respond to their needs – whether in long-term care homes or in the community.

   This initiative focuses on people over the age of 65 years who have significant emotional, behavioural or cognitive problems which interfere with their ability to function independently or which seriously affect their feelings of well-being and relationships with others. This initiative involves the development of a model of care, the establishment of protocols between tertiary, Schedule 1, Long-Term Care Homes and community agencies, the creation of an evaluation framework, and installation and use of telemedicine equipment to enhance clinical interventions

4. South West Self Management Strategy (Chronic Disease Prevention and Management Peer Support, Caregiver Support and Self-Management Tools) - The South West LHIN initiated a program focused on enabling health service providers within the region to expand their skill set to empower their patients with one or more chronic disease(s) to self manage their condition. Coaches across the LHIN have been trained and many people are participating in workshops that provide them with skills and knowledge to better care for themselves.

   Work continues in improving access to chronic kidney disease (kidney dialysis) services through satellite locations of the London Regional Renal Program, as well as through the use of peritoneal dialysis at some long-term care homes in the South West.

5. Quality & Process Improvement Program
   - First report (on milestones only) due June 7, 2011
   - Reporting on indicators expected as individual projects start up

The South West LHIN AAH team is confident that the existing AAH programs have impacted the three performance domains across the continuum of care that include "prevention & promotion", "acute" and "recovery & maintenance". Each program is delivering the services that were intended and for some, the potential exists to spread to other geographical areas of the LHIN (e.g. Falls Prevention), or even to other LHINs (e.g. Community Stroke Rehab).

eHealth Initiatives in the South West LHIN

New leadership helped propel the South West LHIN's eHealth initiatives to new heights throughout 2010 and into 2011 as clinical and information technologies played an increasingly important role in the quality of care patients receive.

The South West LHIN's Chief Information Officer joined the LHIN mid-year and immediately took on the task of creating and implementing a shared LHIN-wide eHealth Strategic Plan to help medical professionals focus their eHealth investments on those information and clinical technologies that will have the biggest impact.

That plan – developed through an extensive stakeholder engagement process and aligned with the South West LHIN's Integrated Health Service Plan (IHSP 2010-13), the Health System Design Blueprint – Vision 2022, and the provincial eHealth strategy – was approved by the South West LHIN's Board of Directors in December 2010.

In the meantime, projects like the Southwest Physicians' Office Interface to Regional Medical Record (SPIRE) continued to grow by leaps and bounds. By the end of fiscal, more than 350 physicians were connected to the SPIRE, making it one of the most successful eHealth projects in the province. SPIRE provides a secure electronic interface between hospitals' Electronic Patient Records (EPR) and participating regional physicians' offices, saving physicians time and money while improving the quality of patient care.

eShift – a Community Care Access Centre (CCAC) project that uses technology to extend the reach of health care services, dollars and personnel – is another South West LHIN success story. Using a web-enabled telephone, the initiative connects a nurse to an enhanced-skill Personal Support Worker providing overnight home care to clients with complex health care needs. What started with a pilot project in the homes of medically fragile children has now been expanded to include palliative care patients to the far reaches of Grey County.

Of particular note was the completion of the Southwestern Ontario Diagnostic Imaging Network which enables access to filmless diagnostic images including x-rays, CT scans and MRIs from any acute care facility in the Erie St. Clair and South West LHINs. Work is underway to integrate hospitals in the Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs as well; when complete, the network will manage more than 3 million exams annually and save the health care system as much as a billion dollars a year.

Looking forward, the South West LHIN – again in collaboration with the Waterloo Wellington, Erie St. Clair and Hamilton Niagara Haldimand Brant LHINs – is in the initial planning stage of the 'Connecting South Western Ontario' (c-SWO) project to create a robust, scalable, reusable, standards-based platform for integrated data exchange. Although still in its infancy, c-SWO will ultimately lead to a provincial integrated Electronic Health Record (iEHR).

Community Engagement Activities

Over the past year, the South West LHIN has been striving to achieve five system level goals: A Healthier South West LHIN Community; Equitable Access to Services; Quality of Care and Service; Integration of Health Care Delivery; and, Sustainability of the South West Local Health System. The Blueprint – Vision 2022 and Integrated Health Service Plan 2010-2013 are grounded in these as well as the LHIN's vision, mission and values. The South West LHIN is working collaboratively with health system partners to implement the actions to create an integrated health care system, where quality care is delivered as close to home as possible.

The delivery of quality care within a dynamic, ever-evolving environment will happen if we work together to create system change. Health system partners are building a health care system where programs and services work together, where individuals and their families are able to access and receive the care they need, when they need it. We are putting patients and clients at the centre of the system, closing gaps between services and removing duplication.

The South West LHIN is responsible for engaging health care providers, consumers, volunteers and the public in the work that lies ahead. Through these engagement activities, the LHINs and health service providers are able to gather and share information with their communities and stakeholders.

The South West LHIN continues to develop its engagement activities and plans based upon the International Association for Public Participation (IAP2) model. Building on this model, the LHIN Community Engagement Guidelines and Toolkit were created and released in February 2011. These guidelines complement the community engagement that the South West LHIN has already undertaken, and will further the LHIN's accountability and transparency.

This past year, the South West LHIN conducted a number of engagement activities that included both targeted, topic-specific engagement sessions as well as ongoing, regular engagement opportunities aligned to our health system goals.

Targeted Engagement

CAPS, M-SAA and H-SAA Webcasts: Four webcasts were delivered in January and February 2011 to inform our community and hospital health service providers about the 2011-14 Community Accountability Planning Submission (CAPS), Multi-Sector Service Accountability Agreement (M-SAA) and 2008-12 Hospital Service Accountability Agreement (H-SAA) Amendment (extension) processes, provide training and to invite comments and suggestions to improve the planned process. Following the webcasts, providers completed the required submissions and all agreements were renewed. The process for each submission was modified based on the feedback received. Going forward, community and hospital health service providers will be engaged in performance management activities.

Life or Limb – No Refusal Policy Regional Engagement Session: Prior to the policy kick-off, a workshop was held in February 2011 to provide information to stakeholders and an opportunity for discussion about the impacts of implementation of the Life or Limb – No Refusal Policy across the South West LHIN. Hospital providers who will be responsible for operationalizing the policy at the ground level provided feedback and assisted us in understanding the areas of concerns and communication requirements to ensure successful implementation.

Orthopaedics: In the past year, several engagement opportunities occurred with hospital CEOs, orthopaedic surgeons and family physicians (e.g., focus groups, one-on-one meetings, surveys). Most of these opportunities centred on issues regarding access to hip and knee replacement surgery, including the best time to refer a patient for an orthopaedic consult, and how to improve our time to surgery for people who have had a hip fracture. At the LHIN Hospital and CCAC Leadership Forum,

leaders identified improving access to emergent hip fracture surgery as a priority. This led to the funding of a LHIN-wide improvement project to achieve provincial target of access within 48 hours.

Ongoing Engagement

The South West LHIN believes that true engagement is ongoing, regular, and meaningful. Every meeting, every community event, every conversation is an opportunity to engage our stakeholders.

Health care providers and the public are informed of our engagement opportunities and invited to provide input and feedback to us through a variety of vehicles, including social media. Since 2010, the South West LHIN has had a presence on YouTube, Twitter, Facebook and Linked In, all of which have provided ongoing opportunities for engagement.

Again this year, we partnered with the Ontario Medical Association to host *three physician engagement workshops*, one in each of our three geographic planning areas of the South West LHIN.

The objectives of the sessions were to:

- Update physicians on the activities of the South West LHIN;
- Obtain guidance from physicians on key priorities in the South West;
- Give physicians the opportunity to learn about proposed changes to the health care system, identify the processes that will affect physicians and discuss physicians' leadership role in system change.

Participants attended the "Quality Care and the Excellent Care for All Act" Plenary session where Dr. Ben Chan (CEO, Ontario Health Quality Council) or Dr. Anne DuVall (President, Ontario College of Family Physicians) delivered key notes presentations on the focus on quality improvement as an enabler to health system transformation and the provincial context related to quality and potential implications/roles for physicians.

The workshop also included concurrent sessions:

- "Your Role in Influencing Your Hospital's Quality Agenda" – Panel presenters, including one hospital Board Chair, one hospital CEO and one Chief of Staff from the local area, provided their view regarding the Excellent Care for All legislation and the opportunity that physicians will have to influence quality within hospitals and across the health care system.
- "Centralized Access: Good for Patients, Good for Doctors?" – The session explored issues of access and wait times by illustrating some of the work that has been initiated in our LHIN and the impact on physicians and their patients.
- "eHealth as an Enabler" – The session described and explored the South West LHIN eHealth Strategy, current eHealth projects, future funding opportunities and the impact on primary care physicians.

Each of the sessions was well attended and the session evaluations were generally positive. Overall, the majority (76%) of the respondents were satisfied and very satisfied with the event.

In addition to our annual LHIN/OMA physician workshops, we engaged with physicians and other health care professionals with several new activities.

The *South West Primary Care and Cancer Network* is composed of eight primary care physicians and one nurse practitioner and meets approximately eight times per year to discuss various issues and initiatives that impact primary care practitioners and patients. In addition to regularly attending Network meetings and providing updates, South West LHIN staff received feedback in January on the following items:

- Activities across the South West LHIN to improve Diabetes Care, such as the Diabetes Registry and Regional Coordination Centre
- An update on Partnerships For Health and plans for spread and sustainability
- The Hips and Knees referral form

Engagement with Aboriginal and Francophone Communities

Aboriginal Engagement

A significant amount of aboriginal engagement occurred in 2010-11. The year began with the South West LHIN's third annual gathering on April 8th. With just under one hundred registrants, there was representation from area First Nations, Aboriginal Health Access Centres, Indian Friendship Centres and Aboriginal Healing Lodges and Treatment Centres. Participants also included mainstream health care providers, including hospitals and community health centres.

One of the main outcomes of the gathering was the development of a cultural safety strategy, including the production of a cultural safety handbook, "*Aboriginal Cross Cultural Reference for Health Care Providers*". This book provides tools and resources to assist health care providers in providing culturally competent health care to the Aboriginal community. The South West LHIN also funded the position of Cultural Safety Trainer for the Supporting Aboriginal Seniors at Home (SASH) program whose role is to develop and deliver workshops and information packages which will educate community health care providers about Aboriginal culture and traditional healing practices throughout the Southwest Local Health Integration Network area.

The South West LHIN is an active member of the Aboriginal Committee whose terms of reference define the following activities:

- Dialogue, advise, and partner with member organizations and with other appropriate bodies to identify needs and bring respective expertise and resources to joint initiatives to address those needs
- Provide advice to the LHIN staff with regard to community issues and solutions;
- Coordinate with other advisory and working groups to ensure LHIN senior management is aware of regional Aboriginal community views, issues and initiatives;
- Promote and participate in gatherings to exchange information, discuss issues and ideas with Aboriginal citizens, their communities and service organizations;
- Facilitate appropriate Aboriginal representatives to various committees as requested.

The South West LHIN Aboriginal Committee held six meetings in the past year.
Aging at Home funds were also allocated to support enhances services for Aboriginal communities with particular focus on diabetes, primary health care and cultural competency.

Francophone Engagement

On January 1, 2010 a new regulation under Section 16 of the Local Health System Integration Act, 2006 came into effect to support coordinated and effective engagement of Francophone communities on French Language Health Services issues. This regulation outlines how the ministry has selected French language health planning entities to work with the Local Health Integration Networks (LHINs). The Minister of Health and Long-Term Care named the South West LHIN planning entity on December 15, 2010. The entities will advise the LHINs on:

- methods of engaging the Francophone community in the area;
- the health needs and priorities of the Francophone community in the area, including the needs and priorities of diverse groups within that community;
- the health services available to the Francophone community in the area;
- the identification and designation of health service providers for the provision of French language health services in the area;

- strategies to improve access to, accessibility of and integration of French language health services in the local health system; and
- the planning for and integration of health services in the area.

LHINs across the province also took steps to hire a French Language Services Coordinator to work as a liaison between the LHIN and the francophone communities, as well as collaborate with the planning entities. As of the end of fiscal 2010-11, the South West LHIN is in the process of recruiting a French Language Services Coordinator and expects to complete the hiring process early in the spring of 2011.

Integration Activities

The *Local Health System Integration Act, 2006* (the 'Act') was passed to:

> *"provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs)."*

The Act places an obligation on LHINs *and* on Health Service Providers to identify opportunities to integrate services through a broad range of activities including co-ordination, partnering with others, and transferring, merging or amalgamating services. Following are the service integrations that were initiated or fully implemented in the South West LHIN in 2010-11.

Central Supply/Sterilization Department Closure
Integration Partners: Listowel Wingham Hospital Alliance - The recently built sterilization department at the Listowel site meets all of the necessary standards and now provides sterilization for the Wingham site. This integration, which was fully implemented on November 1, 2010, resulted in the lay-off notice to one employee, but was in the interest of patient safety and compliance with the necessary standards.

Huron Perth Community Services Unification
Integration Partners: Town and Country Support Services, Midwestern Adult Day Services, Stratford Meals on Wheels and Neighbourly Services - These three community support agencies proposed unification of their organizations with the goal to become one entity as of January 1, 2011. The integration was implemented and as of January 1, 2011 is now formally called "ONE CARE Home and Community Support Services".

Tier 2 Transfer of Specialized Mental Health Services from St. Joseph's Health Care London to Grand River Hospital
Integration Partners: St. Joseph's Health Care London (SJHC) and Grand River Hospital (GRH) - This integration was in regard to the Transfer of 50 beds, 1 Assertive Community Treatment (ACT) Team and 1 Transition Team from SJCH to GRH. This transfer represented the first phase of a multiple transfer of psychiatric beds across 4 LHINs (Erie St. Clair, South West, Waterloo-Wellington, and Hamilton Niagara Haldimand Brant). This transfer was completed in December 2010.

Huron Addiction Services and Choices for Change
Integration Partners: Choices for Change (CFC) Alcohol, Drug & Gambling Counseling Centre and Huron County Health Unit – Huron Addiction Services (HAS) - At its July 14 meeting, the Board of Directors for CFC agreed to move forward with integrating HAS with CFC's operations. CFC subsequently submitted an integration through funding proposal and a request for one-time financial assistance to support the integration process to the South West LHIN. This integration was implemented and CFC is now providing addiction services to Huron County. As a result, the M-SAA with HAS was terminated on December 31, 2010, funding terminated to HAS on December 31, 2010 and funding commenced to CFC effective January 1, 2011.

Huron Perth Healthcare Alliance Vision 2013
Integration Partners: Huron Perth Hospital Alliance (HPHA)

In 2010, the HPHA began the process of implementing their vision for health services that ensures the future sustainability of hospital-based

care for the residents of their catchment area. The HPHA Vision 2013 involves three main components:

1. Create Critical Mass through Bed Redistribution: in order to improve access to medical and surgical beds, Vision 2013 includes a plan to redistribute bed types across the four sites.
2. Realignment of Services: to facilitate recruitment and retention as well as ensure high quality, safe care, Vision 2013 includes a plan to create more consistent groupings of patients among its four sites.
3. Adjust ER Hours to Strengthen ER System of Care: to increase recruitment, stabilize retention, and reduce the risk of unplanned ER closures due to physician and nursing coverage issues, the HPHA Vision 2013 plan includes two 24/7 ER's and two 16/7 ER's across its four sites.

This integration went to the South West LHIN Board of Directors for formal consideration on November 24, 2010, and implementation will take place throughout the 2011-12 fiscal.

Regional Director of Pharmacy
Integration Partners: Huron Perth Hospital Alliance (HPHA) and Alexandra Marine and General Hospital (AMGH) - On October 27, 2010, the HPHA and AMGH submitted an integration request to the South West LHIN to jointly recruit a Regional Director of Pharmacy. Staff will remain employees of their respective organization and the Director will be a HPHA employee though jointly responsible to both organizations as equal partners. The motivation for establishing a Regional Director is to provide vision and strategic management in the development, coordination and delivery of an effective and cost-efficient multi-organizational, multi-site pharmaceutical program.

CMHA and London & District Distress Centre
Integration Partners: Canadian Mental Health Association – London Mental Health Crisis Services (CMHA - LMHCS) Program and London District Distress Centre (LDDC) - The core purpose of this Collaborative Partnership is to provide better service to people in the London community who are experiencing a mental health crisis. This will be achieved by the LDDC answering all crisis calls for the LMHCS and then triaging the calls that require face to face intervention forward to the LMHCS. This integration, expected to be implemented in 2011-12, will allow the LMHCS to expand crisis services without requiring additional funds from the LHIN to do so, even with the administrative cost factored in for the LDDC to provide this service.

Completing the Journey of Acute Care Restructuring in London (Milestone 2 Phase 2 and Phase 3)
Integration Partners: London Health Sciences Centre (LHSC) and St. Joseph's Health Care London (SJHC) - This integration was based on the Health Services Restructuring Commission (HRSC) report provided to London's hospitals in 1997. Within Milestone 2 there are 3 phases:

Phase 1 is complete. This included:

- 42 internal hospital moves
- 23 clinical program transfers between LHSC and SJHC from 1998 to 2005
- Consolidation of Emergency Departments
- Opening of Urgent Care Centre and move of substantive inpatient care from South Street Hospital, LHSC and SJCH to Victoria Hospital
- 275 staff were transferred to LHSC

Phases 2 and 3 went to the South West LHIN Board of Directors for formal consideration on February 23, 2011. In 2011/12, LHSC and SJHC, London will continue to move forward with Milestone 2 Phase 2 (M2P2) and Phase 3 (M2P3) activities.

M2P3 marks the end of the HSRC directed projects. As the activities associated with each Phase progress, the South West LHIN will consider any proposed transfers or integrations of services.

Ministry/LHIN Accountability Agreement Performance Indicators
2010-2011

Performance Indicator	Provincial Target	South West LHIN 2010/11 Starting Point	South West LHIN 2010/11 Performance Target	South West LHIN 2010/11 Most Recent Quarter Performance	South West LHIN 2010/11 Annual Performance Result	Ontario 2010/11 Annual Performance Result
90th Percentile Wait Times for Cancer Surgery	84 days	91	80	104	93	60
90th Percentile Wait Times for Cardiac By-Pass Procedures	182 days	55	55	46	49	49
90th Percentile Wait Times for Cataract Surgery	182 days	85	85	99	93	123
90th Percentile Wait Times for Hip Replacement	182 days	151	151	221	186	181
90th Percentile Wait Times for Knee Replacement	182 days	166	166	209	198	197
90th Percentile Wait Times for Diagnostic MRI Scan	28 days	107	81	67	67	116
90th Percentile Wait Times for Diagnostic CT Scan	28 days	34	28	28	29	33
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	9.46%	11.59%	8.80%	10.32%	10.67%	16.24%
90th Percentile ER Length of Stay for Admitted Patients	8 hours	25.40	25.00	30.43	26.42	32.15
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8 hours	6.30	6.30	6.60	6.45	7.57
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4 hours	4.00	4.00	3.92	3.88	4.38
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	tbd	14.80%	12.50%	13.98%	14.85%	17.50%
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	tbd	22.70%	19.00%	25.48%	28.36%	27.60%
Readmission within 30 Days for Selected case mixed groups**	tbd	16.00%	14.20%	16.28%	15.84%	15.87%

** FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability
*** FY 2010/11 is bassed on only 3 quarters of data (Q1-Q3 2010/11) due to availability

The following page prrovides greater details on activities within the LHIN relating to the above performance indicators.

The South West LHIN is pleased with several system performance achievements over the past year. Our 2010/11 performance results demonstrate good progress in improving wait times for diagnostics and cardiac care. Working alongside our provider partners we were also able to maintain performance in patient flow through the system as demonstrated by emergency room wait times and transitions to alternate and appropriate care settings.

Improving point of care transitions for patients remained at the centre of our work with our partners over the past year. For example, our hospital sites and the Community Care Access Centre achieved great success in enhancing patient access to quality care and ensuring transitions between care settings were improved through the introduction of the LHIN-wide *One Number* protocol which focuses on timely communication between referring hospital sites for more seamless access to quality care. The protocol is also helping maintain an appropriate distribution of services across the LHIN, maximizing human resources and ensuring people receive care as close to home as possible.

In order to better understand the care needs of Alternate Level of Care (ALC) patients (individuals who no longer require acute care but remain in hospital) waiting in hospital longer than 40 days, the South West LHIN commissioned a detailed review of each long stay patient. The review prompted an immediate 17% reduction in long stay patients and an overall reduction of the ALC patient count by 42%. This review was successful in transitioning patients who could be discharged with the required supports, reclassifying others, and prompting changes to policies and procedures. Efforts to have more individuals discharged with the required supports are ongoing.

The South West LHIN and provider partners still have more work to do. Surgical wait times for hip and knee total joint replacements have reversed from earlier trend.

Cancer surgery wait times remain high. Over 76% of cancer surgeries are provided within the London hospitals. A focused plan was launched to target "long wait" cases, refine and implement models for queuing patients, and reengineer access to specialist processes. A revised surgical case distribution plan is also being reviewed to ensure other hospital sites with surgical capacity are part of the solution. The LHIN and provider partners are committed to improving performance, lowering wait times to ensure people have access to timely care.

The other area for performance improvement relates to return visits by mental health and addictions clients in emergency rooms. The metrics track people returning to an emergency room and highlight the need for our acute and community provider partners to have an integrated and shared approach to service delivery. In 2010/11, the LHIN initiated a community capacity project with the goal of identifying ways to invest in new and reconfigure existing services within the community to better care for mental health and addictions clients. This work will take more time to fully realize the benefits and all partners remain committed to improving the continuity of care for these clients.

The South West LHIN remains committed to achieving our performance improvement goals as part of our overall plan to achieve an integrated health system of care. Although we are pleased with our progress we know we can continue to lower wait times, enhance quality of care, improve transitions between care settings, and increase patient/client satisfaction.

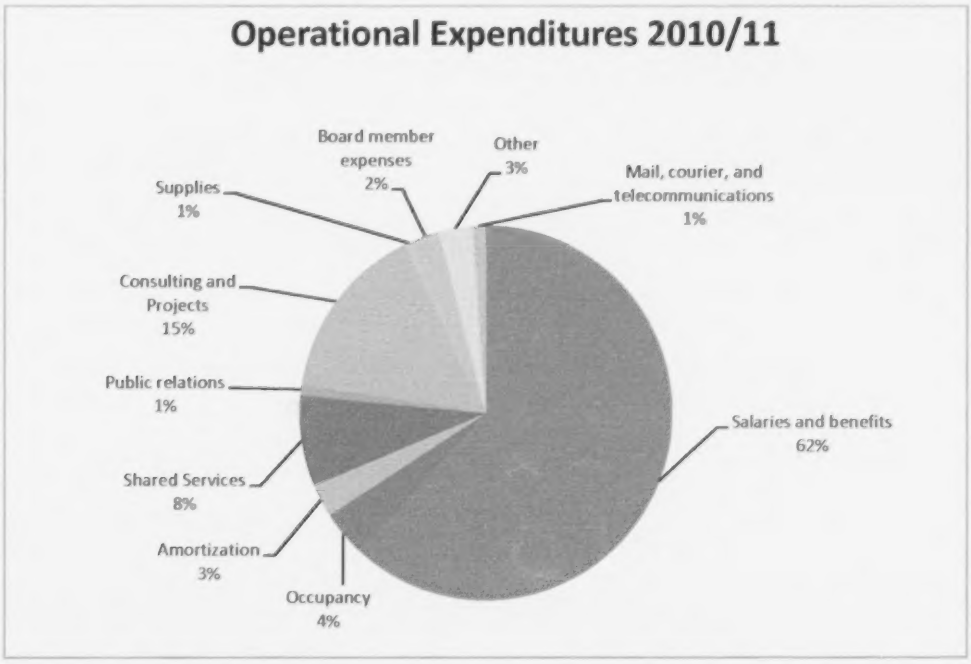
Operational performance

In 2010/11, the South West LHIN operating budget was made up of two components:

$5.2 million for operations
$1.2 million for special projects

Operations

The South West LHIN ended the year with an operating surplus of $12,095. There were small surpluses relating to the funding for other special projects. The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure is salaries and benefits with 31 FTEs and 8 staff hired on contract basis for specific projects.



Special Projects

The one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2010/11 fiscal year were:

	Funding	Expenditure
Aboriginal Planning	4,702	4,702
French Language Services	10,000	9,318
Critical Care Lead	75,000	74,643
E-Health	940,795	936,039
Emergency Department Lead	51,817	38,810
Emergency Room/Alternative Level Care Lead	100,000	97,676
Total	**1,182,314**	**1,161,188**

Financial Statements of the

South West Local Health Integration Network

March 31, 2011

South West Local Health Integration Network

March 31, 2011

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of financial activities 4

Statement of changes in net debt 5

Statement of cash flows 5

Notes to the financial statements 6-12

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
South West Local Health Integration Network

We have audited the accompanying financial statements of South West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2011, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audits is sufficient and appropriate to provide a basis for our audit opinion.

Membre de / Member of Deloitte Touche Tohmatsu

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2011 and the results of its financial activities, changes in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 25, 2011

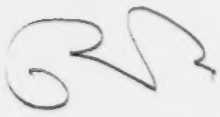
South West Local Health Integration Network

Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**525,094**	705,687
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**37,412,887**	16,382,394
Due from MOHLTC	**-**	107,000
Due from the LHIN Shared Services Office (Note 4)	**3,736**	3,343
HST Receivable	**65,468**	-
Accounts receivable	**1,421**	6,368
	38,008,606	17,204,792
Liabilities		
Accounts payable and accrued liabilities	**581,241**	576,742
Due to Health Service Providers ("HSPs") (Note 9)	**37,412,887**	16,382,394
Due to MOHLTC (Note 3b)	**28,518**	173,656
Due to the LHIN Shared Services Office (Note 4)	**7,631**	-
Deferred revenue (Note 10f)	**-**	72,000
Deferred capital contributions (Note 5)	**409,415**	504,144
	38,439,692	17,708,936
Commitments (Note 6)		
Net debt	**(431,086)**	(504,144)
Non-financial assets		
Prepaid expenses	**21,671**	-
Capital assets (Note 7)	**409,415**	504,144
Accumulated surplus	**-**	-

Approved by the Board

Jeff Low, Board Chair



Ron Bolton, Audit Committee Chair

South West Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**1,958,148,082**	**2,096,400,627**	1,996,757,391
Operations of LHIN	**5,112,220**	**5,099,732**	4,963,133
Aboriginal Planning (Note 10a)	-	**4,702**	35,525
Diabetes (Note 10b)	-	-	98,178
E-Health (Note 10c)	**600,000**	**940,795**	549,092
Emergency Department ("ED") Lead (Note 10d)	**75,000**	**51,817**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10e)	-	**100,000**	100,000
French Language Services (Note 10f)	**72,000**	**10,000**	-
Critical Care (Note 10g)	-	**75,000**	-
Amortization of deferred capital contributions (Note 5)	**149,630**	**149,628**	325,756
	1,964,156,932	**2,102,832,301**	2,002,904,075
Expenses			
Transfer payments to HSPs (Note 9)	**1,958,148,082**	**2,096,400,627**	1,996,757,391
General and administrative (Note 11)	**5,261,850**	**5,237,266**	5,269,071
Aboriginal Planning (Note 10a)	-	**4,702**	35,777
Diabetes (Note 10b)	-	-	81,042
E-Health (Note 10c)	**600,000**	**936,039**	486,923
ED Lead (Note 10d)	**75,000**	**38,810**	60,356
ER/ALC Performance Lead (Note 10e)	-	**97,676**	105,701
French Language Services (Note 10f)	**72,000**	**9,318**	-
Critical Care (Note 10g)	-	**74,643**	-
	1,964,156,932	**2,102,799,081**	2,002,796,261
Annual surplus before funding repayable to MOHLTC	-	**33,220**	107,814
Funding repayable to the MOHLTC (Note 3a)	-	**(33,220)**	(107,814)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

South West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	Budget (unaudited) (Note 8)	2011 Actual	2010 Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	**(21,671)**	-
Acquisition of capital assets	-	**(54,899)**	(154,485)
Amortization of capital assets	-	**149,628**	325,756
Decrease in net debt	-	**73,058**	171,271
Opening net debt	-	**(504,144)**	(675,415)
Closing net debt	-	**(431,086)**	(504,144)

South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2011

	2011	2010
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**149,628**	325,756
Amortization of deferred capital contributions (Note 5)	**(149,628)**	(325,756)
Changes in non-cash operating items		
Increase in due from MOHLTC HSP transfer payments	**(21,030,493)**	(14,268,836)
Decrease (increase) in due from MOHLTC	**107,000**	(107,000)
Increase in due from LHIN Shared Services Office	**(393)**	(3,343)
Decrease (increase) in accounts receivable	**4,947**	(3,542)
Increase in HST receivable	**(65,468)**	-
Increase (decrease) in accounts payable and accrued liabilities	**4,499**	(597,256)
Increase in due to HSPs	**21,030,493**	14,268,836
(Decrease) increase in due to MOHLTC	**(145,138)**	107,814
Increase (decrease) in due to LHIN Shared Services Office	**7,631**	(17,883)
(Decrease) increase in deferred revenue	**(72,000)**	72,000
Increase in prepaid expenses	**(21,671)**	-
	(180,593)	(549,210)
Capital transactions		
Acquisition of capital assets	**(54,899)**	(154,485)
Financing transactions		
Deferred capital contributions received (Note 5)	**54,899**	154,485
Net decrease in cash	**(180,593)**	(549,210)
Cash, beginning of year	**705,687**	1,254,897
Cash, end of year	**525,094**	705,687

1. Description of business

The South West Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Provider ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairments in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use, during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2011 surplus	2010 surplus
	$	$	$	$
Transfer payments to HSPs	2,096,400,627	2,096,400,627	-	-
LHIN operations	5,249,361	5,237,266	12,095	19,818
Aboriginal Planning	4,702	4,702	-	(252)
French Language Services	10,000	9,318	682	-
Diabetes	-	-	-	17,136
Critical Care	75,000	74,643	357	-
E-Health	940,795	936,039	4,756	62,169
ED Lead	51,817	38,810	13,007	14,644
ER/ALC Lead	100,000	97,676	2,324	(5,701)
	2,102,832,302	2,102,799,081	33,220	107,814

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2011	2010
	$	$
Due to MOHLTC, beginning of year	173,656	65,842
Funding repaid to MOHLTC	(173,656)	-
Funding receivable from the MOHLTC related to current year activities (Note 10a)	(4,702)	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	33,220	107,814
Due to MOHLTC, end of year	28,518	173,656

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end is recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**504,144**	675,415
Capital contributions received during the year (Note 12)	**54,899**	154,485
Amortization for the year	**(149,628)**	(325,756)
Balance, end of year	**409,415**	504,144

6. Commitments

The LHIN has commitments under various operating leases extending to 2015 related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next four years are as follows:

	$
2012	249,223
2013	209,216
2014	198,349
2015	82,645

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs, based on the current accountability agreements, are as follows:

	$
2012	2,025,460,221

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Computer equipment	**133,685**	**72,999**	**60,686**	24,445
Leasehold improvements	**1,464,863**	**1,220,150**	**244,713**	347,279
Office equipment, furniture and fixtures	**206,997**	**102,981**	**104,016**	132,420
Web development	**21,998**	**21,998**	**-**	-
	1,827,543	1,418,128	409,415	504,144

8. Budget figures

The budgets weree approved by the Government of Ontario. The budget figures reported in the statement of financial activities reflect thhe initial budget at April 1, 2010. The figures have been reported for the purposes of these statements to comply with PSABB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP fundding budget of $2,096,400,627 is derived as follows:

	$
Initial budget	1,958,148,082
Adjustment duee to announcements made during the year	138,252,545
Final HSP fundding budget	2,096,400,627

The final operatinng budget, excluding HSP funding, of $6,435,521 is derived as follows:

	$
Initial budget	6,008,850
Additional fundiing received during the year	481,570
Amount treated as capital contributions during the year	(54,899)
Final LHIN opeerating budget	6,435,521

9. Transfer paymenhts to HSPs

The LHIN has authhorization to allocate funding of $2,096,400,627 to various HSPs in its geographic area. The LHIN approved transfer paymenhts to various sectors in 2011 as follows:

	2011	2010
	$	$
Operation of hoospitals	**1,528,366,263**	1,478,403,457
Grants to comppensate for municipal taxation - public hospitals	**451,500**	451,650
Long term caree homes	**276,650,300**	246,734,108
Community carre access centres	**170,394,969**	162,409,737
Community suppport services	**34,953,026**	29,644,098
Assisted living s services in supportive housing	**16,619,916**	15,959,228
Community heaalth centres	**12,404,709**	8,712,310
Community meental health addictions program	**56,559,944**	54,442,803
	2,096,400,627	1,996,757,391

The LHIN receivess funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2011, an amount of $37,412,887 (2010 - $16,382,394) was receivable from MOHLTC, and was payable to the HSPs. These amounts have been reflected as reverenue and expenses in the statement of financial activities and are included in the table above.

10. a) **Aboriginal Planning**

The MOHLTC provided the LHIN with $34,992 (2010 - $35,525) related to aboriginal planning. The MOHLTC collected from the LHIN, $35,000 as an in year recovery. The LHIN incurred operating expenses totaling $4,702 (2010 - $35,777). The LHIN has setup a receivable from the MOHLTC for $4,702 to cover these operating expenses.

b) **Diabetes**

The MOHLTC provided the LHIN with $0 (2010 - $98,178) related to diabetes management strategy funding. The LHIN incurred operating expenses totaling $0 (2010 - $81,042).

c) **E-Health**

The E-Health office of the MOHLTC provided $942,000 (2010 - $600,000) to the LHIN. During 2011 the LHIN hired a CIO to complement the E-Health project management office while incurring operating expenses of $936,039 (2010 - $486,923) and capital expenses of $1,205 (2010 - $50,908) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to the MOHLTC for the remaining balance of $4,756.

d) **ED Lead**

The MOHLTC provided the LHIN with $75,000 (2010 - $75,000) to hire a LHIN representative for emergency department planning. The MOHLTC collected from the LHIN, $23,183 as an in year recovery. Dr. Lisa Shepherd was selected and remunerated a total of $38,810 (2010 - $60,356) through a monthly per diem and expense allowance as described by the MOHLTC. Dr. Shepherd resigned in November 2010. The LHIN has setup a payable to the MOHLTC for the remaining balance of $13,007.

e) **ER/ALC Lead**

The MOHLTC provided the LHIN with $100,000 (2010 - $100,000) related to emergency room management strategy funding. The LHIN incurred operating expenses totaling $97,676 (2010 - $105,701) and has setup a payable to the MOHLTC for the remaining balance of $2,324.

f) **French Language Services**

The MOHLTC provided the LHIN with $110,000 (2010 - $0) related to French Language Services funding. The MOHLTC collected from the LHIN, $100,000 as an in year recovery. The LHIN incurred operating expenses totaling $9,318 (2010 - $0). The LHIN has setup a payable to the MOHLTC for the remaining balance of $682.

The MOHLTC allowed the LHIN to retain $72,000 related to French Language Services at the end of fiscal 2010 until the end of August 2010. No related expenses were incurred in fiscal 2011 and no funds were allocated in fiscal 2011 (2010 - $72,000).

g) **Critical Care**

The MOHLTC provided the LHIN with $75,000 (2010 - $0) related to Critical Care initiatives. The LHIN incurred operating expenses totaling $74,643 (2010 - $0). The LHIN has setup a payable to the MOHLTC for the remaining balance of $357.

11. General and administrative expenses

The statement of financial activities presents the expenses by function; the following classifies general and administrative expenses by object:

	2011	2010
	$	$
Salaries and benefits	3,242,761	2,865,731
Occupancy (Note 12)	205,399	240,561
Amortization	149,628	325,756
Shared services	359,495	362,714
LHIN Collaborative	50,000	12,286
Public relations	50,986	139,432
Consulting and Project expenses	801,032	664,610
Supplies	36,413	82,516
Board chair per diem	24,275	25,900
Board member per diem	54,017	65,010
Board member expenses	49,004	133,228
Mail, courier and telecommunications	59,604	130,495
Other	154,652	220,832
	5,237,266	5,269,071

12. Recovered expenditures

The LHIN has an agreement with the Southwest Community Care Access Centre ("CCAC") to introduce a Chronic Disease Prevention and Management ("CDPM") Project. The CCAC will pay the cost of accommodations and initial office set-up on behalf of the CDPM to the LHIN.

During the 2011 fiscal year, amounts received for accommodations decreased occupancy expense by $58,200 to $205,399 from $263,947 (2010 - $58,200 to $240,561 from $298,761) and is included in the statement of financial activities.

13. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 30 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $262,137 (2010 - $256,430) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan on December 31, 2010. As that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

Ontario
Local Health Integration
Network

ISSN 1911-2858 June/11 ©2011